Corby Clinical Commissioning Group and Nene Clinical Commissioning Group

Northamptonshire County Council

Policy and Procedure for Medicines Management in the Domiciliary Setting (Adults) for Northamptonshire

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DOCUMENT CONTROL SHEET

Purpose and Scope of document:	To provide guidance to support safe and consistent management of medicines by authorised staff in accordance with current legislation, national and local guidance. To provide a policy which forms part of the contracts for providers of domiciliary care that includes medication support within Northamptonshire This policy applies to assistance with medicines in the domiciliary setting for adults over 18 years of age.
Dissemination:	Available on Northamptonshire County Council (NCC) intranet, Nene CCG intranet and Corby CCG intranet. Shared with all NCC, Nene Clinical Commissioning Group (CCG), Corby Clinical Commissioning Group , Northamptonshire Healthcare Foundation Trust (NHFT) staff via internal intranets
Implementation:	For implementation by staff of NCC, Nene Clinical Commissioning Group (CCG) Corby Clinical Commissioning Group, Northamptonshire Healthcare Foundation Trust (NHFT) and private providers who sign up to this policy.
Review:	Two years after ratification or earlier if there is new national guidance, changes in treatment or legislation.
This document supports (enter Standards and Legislation):	The Medicines Act 1968 The Misuse of Drugs Act (Safe Custody Regulations) 1973 The Misuse of Drugs Act 2001 Health and Safety at Work Act 1974 CQC Fundamental Standards Regulation 9: Person Centred Care Regulation 11: The Need for Consent. Regulation 12: Safe Care and Treatment Mental Capacity Act 2005 Department of Health 2006, Our Health, Our Care, Our Say: A New Direction For Community Services And any other subsequent amendments to all legislation and any relevant law
Key related documents:	Guidance on the use of Monitored Dosage Systems (MDS) Northamptonshire
Contact point for queries	Care Home Advice Pharmacist team 01604 651356 NCC Customer Service centre 0300 126 1000
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INTRODUCTION

Care Quality Commission (CQC) Fundamental Standards , which came into force from April 2015 state:

- *Care and treatment must be appropriate and reflect service users' needs and preferences*
- *Service users must be treated with dignity and respect*
- *Care and treatment must only be provided with consent*
- *Care and treatment must be provided in a safe way*
- *Service users must be protected from abuse and improper treatment*
- *Service users' nutritional and hydration needs must be met*
- *All premises and equipment used must be clean, secure, suitable and used properly*
- *Complaints must be appropriately investigated and appropriate action taken in response*
- *Systems and processes must be established to ensure compliance with the fundamental standards*
- *Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed*
- *Persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed (Fit and proper persons requirement)*
- *Registered persons must be open and transparent with service users about their care and treatment (Duty of Candour)*

All of the above standards (and any subsequent updates) are relevant to the management of medicines in the domiciliary setting.

2.0 AIMS AND OBJECTIVES

Northamptonshire County Council in collaboration with Nene and Corby CCGs have developed this policy in order to

- Ensure that service users' health, wellbeing and independence is promoted with regard to the management of their medicines, in a manner consistent with the CQC Fundamental Standards.
- Provide a framework for the consistent safe and secure management of medicines in the domiciliary setting across Northamptonshire

3.0 ROLES AND RESPONSIBILITIES

Please refer to Section 14, Glossary, for definitions of the roles listed below

3.1 Commissioners of Care Services

It is the Commissioner's responsibility

- Ensure that an initial assessment of the service-user's needs includes the level of support with medication. (See Appendix 1 "Levels of Assistance")
- Ensure that providers continue to reassess the service user's care requirements.
- Ensure that the level of support is stipulated on the care assessment.
- Take into consideration, when commissioning care, any factors which may require more time to be completed safely.
- Ensure that a review is conducted whenever there is a change in the service user's circumstances which may affect the level of support required, or, as a minimum, every year.
- Ensure that all providers of care, including Day Care, Respite, Domiciliary, Supported Living and Home and Community Support are aware of the service user's medication needs.
- Liaise with family members and other informal carers where appropriate.

3.2 Care Provider

It is the Care Provider's responsibility to:

- Ensure that, when agreeing to provide assistance with medication, they have the capacity and capability to do so safely.
- Ensure they have appropriate employee liability insurance.
- Ensure that their staff members comply with this policy.
- Establish, document and maintain an effective system by which medicines are managed safely and securely to meet the service user's care needs.
- Designate an experienced senior member of staff to be responsible for management of this system.
- Ensure that care staff providing assistance with medication, and appropriate manager/senior in charge, have been trained and are competent to do so. (See Section 4, Training and Competency)
- Conduct and maintain a Medicines Risk Assessment for each service user who takes prescribed medication receiving level 1, 2 or 3 support with their medicines.(See appendix 1 "Levels of Assistance")
- Provide a Medication Administration Record (MAR) chart, or ensure a MAR chart is available for their staff to record level 2 or level 3 assistance provided. (See Section 8 MAR Charts)
- Set up a system to assure the source and accuracy of information contained in the MAR chart, and any changes.
- Establish a system by which any changes made after production are evident, i.e. dated, signed and indicates who has made the change.
- Establish an effective system to ensure that any MAR charts which are no longer in use (e.g. from previous months) are removed promptly from the premises and stored as detailed in section 8.9
- Establish a system by which completed (i.e. used) MAR charts are reviewed by a senior, experienced member of staff at least once a month, who reports any discrepancies via Datix or their own incident reporting system and takes appropriate action
- Establish an effective system to ensure that the MAR chart is reviewed following discharge from hospital, and is updated when changes are made to the service user's medication, e.g. following an out-patient appointment.
- Immediately take medical advice in the event of an error occurring, and to fully investigate, document and take necessary measures to prevent recurrence including re-training of staff members if appropriate.
- Monitor the care provision and requirements to ensure the care continues to be delivered and is appropriate.
- Respond to concerns raised by care staff and others about the service user's medicines management.
- Respect the service user's right to refuse medicine on any occasion, and to report refusals and missed doses appropriately.
- Specify in the care plan the details of support with medicines to be provided.

3.3 Care Staff (Formal carers)

It is the responsibility of Care Staff to

- Follow the care plan and this policy with meticulous care and attention. Provide the level of support specified in the care plan:
- Level 1 support (e.g. prompting) in accordance with the care plan and the service user's instructions.
- Only give level 2 or 3 support in accordance with the care plan **and** the prescriber's instructions.
- Meticulously follow the procedure contained in "Instructions for use of Medicines Administration Record (MAR) chart by care workers" when administering medicines (Appendix 2).
- Record level 1 support in the care record.
- Record all level 2 or 3 assistance given on the MAR chart provided. (See Section 8)

- Be alert to any factors which may pose a risk to the service user, and to report any concerns to their manager/senior in charge or the care provider's designated responsible person. This may include concerns about the availability or accuracy of the MAR chart.
- Immediately report any refused doses or mistakes in the administration of medication to their manager/senior in charge, including omitted doses and complete the appropriate documentation.
- **If unable to contact the manager/senior in charge, the care worker should not delay seeking medical advice and record outcomes.**
- Act in a way which would not put themselves or the service user at risk.
- Ensure they have received the necessary training and are competent and confident to provide the care required.

Care Staff are **only** accountable for medication they themselves administer or assist with.

3.4 Registered Nurses

It is the responsibility of a registered nurse to:

- Adhere to their professional practice guidelines.
- Adhere to their organisations' Medicines Management Policy and this policy.

4 TRAINING AND COMPETENCY

Training in medication best practice for independent providers who provide care for service users who live in Northamptonshire is provided by LGSS as "Medication Best practice "
Training sourced elsewhere must incorporate the requirements of this policy and records of training received, competency assessment and dates completed must be recorded for each member of staff.

4.1 Level 1 Support (See Appendix 1 for details of the levels of support)

Any staff providing level 1 support with medication must clearly understand the limits of the support to be provided, and work strictly within the instructions in the care plan

If they have any concerns regarding this, or the service user appears to require a greater level of support, the care worker must report this to their manager/senior in charge promptly.

4.2 Level 2 Support

Care staff must not be permitted to give level 2 support with medication until they have:
Received training in medicines management, and
Been assessed as competent
Competencies should be assessed consistently and re-assessed at least annually.

4.3 Level 3 support

Care staff must not be permitted to give level 3 support with medication unless they have received the necessary specialist training for the task and are deemed competent.
Competency should be assessed at least annually

5 SUPPLY OF MEDICINES

The service user's medicines should already be in the house.
Care staff may collect repeat medicines **only** if this is specified in the care plan.
Care staff may assist with the repeat prescription request **only** if specified in the care plan.

All assistance in obtaining the medicines must be recorded in such a way that other care staff are aware of what has been ordered or collected.

5.1 Over the Counter Medicines (Household Remedies)

Whilst the purchase of medicines or herbal or alternative therapies may take place if requested, medical or pharmaceutical advice should be sought and documented before or at the time of the purchase, in order to reduce the risk of interactions with prescribed medicines.

The use of household remedies or over the counter medicines, **when known**, must be documented, and considered in the initial and ongoing Medicines Risk Assessments before assistance or administration can occur.

6 STORAGE OF MEDICINES

- Medicines must be stored where they are readily accessible to the service user as appropriate and all carers, subject to the Medicines Risk Assessment
- Medicines should be kept out of the reach and sight of children and others to whom they may pose a risk.
- Medicines should be kept away from sources of heat, light and damp.
- Where the product label or packaging specifies defined storage conditions, e.g. refrigeration, this must be followed. If it becomes clear that the specified storage conditions have not been adhered to, the carer or their manager/senior in charge should seek advice from the pharmacy, dispensary, or medicines management team regarding the medicine's suitability for use.
- All medicines must be kept in the packaging in which they were obtained from the pharmacy or dispensary.

6.1 Hiding Medicines and Covert Administration

The best interests of the service user are paramount.

6.1.1 Medicines must **only** be hidden from, or made inaccessible to the service user if this is identified in the Medicines Risk Assessment as necessary to protect the service user from harm and is specified in the care plan.

The decision should be taken following discussion with family members/advocate and, health care professionals as appropriate, and documented in the Medicines Risk Assessment.

6.1.2 Similarly, the covert administration of medicines (e.g. disguising medicines in food or drink) must **only** be considered in exceptional circumstances, following discussion with family members, health and social care professionals etc. as appropriate, taking into consideration the capacity of the service user to consent or refuse treatment, and documented in the Medicines Risk Assessment and the care plan. A DOLS authorisation may also be required. Advice must be sought from a pharmacist regarding the pharmaceutical suitability of the medicine for administration in this way.

Decisions to administer medicines covertly must not be taken by any individual in isolation.

Medicines must not be administered covertly to anyone who is deemed to have capacity to make a decision on whether or not they wish to take medication.

All decisions of this nature must be taken in accordance with Department of Health guidance and the Mental Capacity Act (MCA). They must be fully documented as set out in the MCA code of practice.

6.2 Removal from Original Packaging (Preparing) for level 1 support with medicines

Removal of tablets etc. from their original packaging to be left out for the service user **to take themselves** at a later time may aid their independence.

Any assistance of this nature must:

- Be the subject of a Medicines Risk Assessment and be specified in the care plan
- Take account of the stability of the pharmaceutical preparation, therefore pharmaceutical advice should be sought.
- Be specified in the care plan.
- Be closely monitored and documented by the provider
- Medicines must not be left out for longer than 24 hours
- Any medicines that have not been taken must be disposed of safely (see section 10)

Such assistance is classed as Level 1 support with medicines.

Care staff members are **not permitted** to remove medication from its original packaging for later administration by a third party, such as another care worker or family member.

Care staff **must not** administer medication that has been removed from the packaging by another person.

Assistance with medicines from multicompartmental compliance aids, or those filled by family or informal carers will be limited to prompt only (level 1 support)

7. ADMINISTRATION

Service users should self-administer their medicines whenever possible and appropriate

Medicines must only be administered in accordance with the prescriber's specific instructions.

Care staff may only administer medicines that are correctly labelled by a pharmacy or dispensary with the service user's full name and date of dispensing. The medicine name, prescribed dose and frequency should also be included .Where the dose is variable it should be given in accordance with separately written instructions e.g. warfarin (see 8.7.2) and analgesics.

Tablets must not be crushed or dissolved or capsules opened unless this is stated on the dispensing label, or written instructions received from a healthcare professional.

Medicines must not be given after their expiry date. Note: some medicines have a reduced expiry date after opening. Check pack for details. If in doubt, refer to pharmacist for advice.

If oral liquid medicines need to be measured via a syringe, a designated oral syringe must be used.

Care staff must pay due regard to service users' privacy, dignity and religious/ cultural beliefs at all times. Service users have the right to refuse their medicines if they have capacity and must never be coerced to take them.

The procedure for administration of medicines is included in the **"Instructions for use of**

Medicine Administration Record (MAR) Chart by Care Workers" (Appendix 2)

7.1 Monitored Dosage Systems

Monitored dosage systems (MDS) supplied by a pharmacy should only be used as an aid to compliance for the service user to self-administer. Any support offered by care staff under these circumstances would be restricted to prompt (level 1), and therefore a MAR chart is not required.

Care staff who administer medicines are expected to be able to individually identify each medicine they administer, and record it separately on a MAR chart. Therefore MDS are rarely considered appropriate when giving level 2 support.

There may, however, be a very limited number of situations in which, upon Medicines Risk Assessment and following consultation with a manager/senior in charge it is considered appropriate for care staff to administer from a MDS. E.g. deterioration of cognition in a service user who was previously receiving level 1 support In this case a MAR chart must also be used.

Some MDS systems (usually only available to care homes) may have one medicine per "blister" and each blister has a direction label. These may be treated as if they were original packs.

Reference "Northamptonshire Guidance on the use of Monitored Dosage Systems "

8 MEDICATION ADMINISTRATION RECORDS (MAR CHARTS)

8.1 Purpose of the MAR chart

The MAR chart is the confidential, formal record of administration of medicines. It is required for all service users receiving level 2 or 3 support with medicines, and may be used as evidence in clinical investigations and court cases. It is therefore important that they are clear, accurate and up to date.

MAR charts are not required for level 1 assistance (where the care worker reminds or prompts the service user but does not administer the medicines). This should be recorded in the care record.

The MAR chart must provide an accurate account of the medicines being administered to the service user by the care staff. It should document all prescribed medicines, including externally applied medicines. (Those administered or applied by nurses will be recorded in the nursing record provided by their trust)

8.2 Responsibilities of the Care Provider for MAR charts

It is the responsibility of the provider to:

- Provide a MAR chart, or ensure a MAR chart is available for their staff to record level 2 or level 3 assistance provided. A new chart is required each month or 4 week period.
- Set up a system to assure the source and accuracy of information contained in the MAR chart, and any changes.
- Establish a system by which any changes made after production are evident, i.e. dated, signed and indicates who has made the change.
- Establish an effective system to ensure that any MAR charts which are no longer in use (e.g. from previous months) are removed promptly from the premises and stored appropriately at the office or base
- Establish an effective system to ensure that the MAR chart is reviewed following discharge from hospital, and is updated when changes are made to the service user's medication, e.g. following an out-service user appointment.

8.3 Safe production of MAR charts

The procedure for producing MAR charts should ensure that:

- The MAR chart is individual to the service user and reflects the items which are still being currently prescribed and administered.
- The MAR chart is clear, indelible, and permanent and contains product name, strength, dose and frequency.
- The MAR chart is constructed on the basis of currently prescribed medicines together with information about repeat prescriptions for PRN medicines.
- The MAR chart includes all prescribed externally applied medicines to be administered by care staff and best practice would be to use a body map to show the correct area of administration.
- The MAR chart incorporates a method to ensure that any changes made after production are evident (dated, signed and indicates who has made the change)
- There is a robust system in place to ensure timely removal from the MAR chart of items no longer prescribed or administered, following documented communication to this effect from the prescriber.
- When medicine formulations are changed, for example from a tablet to a liquid version, that the original item is removed from the current and all future MAR charts for that service user.
- When a medicine is included in a MAR chart as two or more differing strengths, it is best practice to place these next to each other on the same MAR chart where appropriate and possible, to help minimise errors.
- When a short course of medicine is prescribed, the MAR chart is clear that this is the case.

8.4 Contents of MAR charts

The MAR chart must detail:

- The service user's details
- Start and end dates
- Known Allergies
- The name and form (e.g. tablets, capsules) of ALL medicines that are to be administered or applied by the care worker
- The time they must be given
- The day of the week, if not daily
- The dose
- The route, if not to be taken by mouth, e.g. "to be inhaled"
- The quantity
- Any important special information e.g. " Do not take indigestion remedies 2 hours before or after you take this medicine "
- The names of those preparing and checking the MAR chart and the date prepared
- If more than one chart is in use, reference to the other charts, e.g. "chart 1 of 2"

This information must exactly match that on the dispensing label provided by the pharmacy or dispensary where these instructions are clear and comprehensive but can be overwritten by a competent care worker if the instructions are poor and do not include how, when and where a medicines should be used.

8.5 Use of MAR charts

See "Instructions for use of Medicine Administration Record (MAR) Chart by Care Workers" (Appendix 2)

Each time a dose is due, the care worker giving it **must** follow the instructions step by step.

They must immediately record administration of a dose by signing the MAR chart in the correct place. The time of administration should be recorded in the care notes, if the actual time administered is not specified, or differs from that on the MAR chart.

Any prescribed medicine **not** given must be clearly recorded as set out in the instructions, and the reason documented.

The information on the MAR chart will be supplemented by the service user's care plan.

It is important that any MAR charts which are no longer in use (e.g. from previous months) are removed promptly from the premises and retained as stated in section 8.9.

8.6 As Required (prn) Medication

Care staff members are **not permitted** to administer these medicines unless there are specific instructions which clarify:

- What the medicine is being used for e.g. Pain
- The minimum interval between doses
- Maximum number of doses in 24 hours
- Quantity of medication to be given (dose)

The MAR chart should also include a review date if known.

The Care Plan should have clear instructions detailing:

- Whether the medicine should be offered at regular intervals to the service user, or only in response to a request from the service user.
- How it is appreciated that the service user requires the medication, detailing non-verbal signals.
- Any further useful information.

Care staff should

- Refer to their manager/senior in charge if this information is not available
- Always check the time of the previous dose in order to ensure that it is within the minimum time interval specified by the prescriber.
- Record the date and time the dose was administered
- Inform their manager/senior in charge, who should contact the service user's doctor, if
  - The service user wishes to take prn medication more frequently than prescribed
  - Consumption increases markedly
  - They have reason to believe the medication is not effective for the service user.
  - They have reason to believe the medication is no longer required.
- Record additional information (such as reason for administration of the medicine) in the care record or on the reverse of the MAR.

It is good practice to record the current balance remaining after each dose has been administered, when practical. This will facilitate good stock management and audit.

- If prn medicines are used infrequently it is important to check before administering:
- That it was originally prescribed for the purpose for which it is now required.

- That the service user is not taking any new medication that might interact with or duplicate it. If in doubt, check with the doctor or pharmacist.
- That it has not been replaced by a different prn or regular medicine more recently prescribed.
- That the supply is still in date, bearing in mind that some medicines have a shortened expiry date once opened. Check pack for details. If in doubt, refer to pharmacist for advice.

8.7 Variable Doses

8.7.1 Service user / Service User Choice

If a variable dose is prescribed (e.g. one or two tablets to be taken if required for pain) the decision regarding the dose to take rests with the service user and the prescriber.

Care staff must:

- Ask the service user how many they wish to take. If the service user is unable to decide or respond the care provider should document in the care plan how they will determine the correct quantity to give. This could be in the form of written instructions from the prescriber
- Care staff are not permitted to assist with these medicines unless and until a decision has been made regarding the dose to be taken, by the service user or the prescriber or by use of the directions in the care plan
- Clearly record on the MAR charts the number of tablets taken.

8.7.2 Warfarin

- The dose of warfarin varies according to results of a blood test.
- It is important to take great care that the correct dose is given, according to the most recent instructions which should be available in the service user's yellow book, or other anticoagulant record.
- The MAR chart must be initialled when dose given, as normal, but in addition the dose given in milligrams (mg) must be written below the carers initials. This should also be recorded in the care record.
- As part of the risk assessment, manager/senior in charge s should ensure they know who to contact in case of queries regarding current dose etc.
- If the yellow book or other anticoagulant record is not available or not up to date care staff should refer to their manager/senior in charge who should **urgently seek** clarification. If unable to obtain clear instructions from a healthcare professional including Out Of Hours (OOH), the manager/senior in charge should instruct the member of staff to continue according to existing dosage instructions until clear information can be obtained, ideally within 24 hours
- Care staff should be vigilant and aware of arrangements for individual service users

Warfarin requires extra caution and in Northamptonshire is classed as level 3 administration

For further guidance please see the Frequently Asked Questions (Appendix 4)

8.8 Changes in Medication

The care provider should have a system to check the source and accuracy of any changes. A cross reference to the care record is recommended.

When a service user's medication is altered, the care provider is responsible for ensuring the MAR is amended as follows:

- The original direction is cancelled
- The new directions are written legibly and in ink on a new line of the MAR The entry is signed and dated

- The date received from the pharmacy or dispensary is recorded in the Medication
- Audit section of the MAR

Alternatively, a new MAR chart may be produced with the correct 'start date' clearly stated.

8.8.1 Discharge from Hospital

When service users leave hospital, even following a short stay, it is likely that changes will have been made to their medicines.

The care provider should have a system to review and update the MAR chart following discharge from hospital.

Information available must include the service users and/or care worker's copy of the Hospital Discharge letter (HDL) listing medication continued, changed, started or stopped and a supply of medicines. The letter may state that some of the medicines are already at home and will not be supplied on discharge
If the care worker identifies any discrepancies between the medicines available and the medicines listed on the HDL he/she should contact the manager/senior in charge for advice. It may be necessary to contact the hospital prescriber or pharmacist for further assistance

The labelled supply sent home with the service user/ own supply at home which is listed on the HDL is the authority to administer those medicines, and supersedes any previous MAR chart. Therefore, if the MAR chart is not yet available, medicines should be administered according to the instructions on the label, and all doses given must be recorded in the care record, with full details of:

Medicine name
Strength
Dose
Time and date administered
The fact that the dose was administered
Signature of the care worker.

The updated MAR chart must be made available as soon as possible.

8.8.2 Verbal Instructions to change medication or doses

Care Staff may only assist with medication according to written instructions, except in the following cases:

- Under very **exceptional circumstances** an individual care worker may accept verbal instructions to change, or stop, **one day's treatment only** from a doctor or other healthcare professional caring for the service user:
  - **Only** the individual receiving the instruction first hand from the doctor or other healthcare professional may act upon this instruction.
  - Verbal instructions must **not** be passed on for action by any other care worker. Written confirmation must be received before others are permitted to carry out the new instructions.

- Under **exceptional circumstances** the care provider's manager/senior in charge may pass on verbal instructions to change, or stop, **one day's treatment only** to care staff, if the prescriber is unable to do so directly, provided:
  - The manager/senior in charge receives the instruction first hand from the doctor or other healthcare professional and carefully records the details of the
    - conversation, and
  - **Only** the individual care worker receiving the instruction directly from their manager/senior in charge may act on the instruction.

Care providers should:

- Request the prescriber to follow up verbal instructions in writing as soon as possible
- Ensure that verbal instructions are fully documented in the care record
- Ensure that the person completing the record
    - Reads their instruction back to the authorising doctor or other healthcare professional as a double-check, preferably in the presence of the service user if appropriate
    - Signs and date the record
    - Records the time and date of the conversation
    - Records the name of the authorising doctor or other healthcare professional
    - Involves the service user as much as possible to ensure they are aware of and consent to the change, and can check the actions of care staff
- Records the dose given in the **care record** with a cross-reference in the MAR chart to the care record, (e.g. "see care record")

- Ensure that the MAR chart is **not** amended, as this applies to a single day's treatment only. Any regular change to medication must be made upon receipt of written authorisation from the doctor or other healthcare professional as set out in 8.8 above.

8.9 Retention of records, including MAR charts

The MAR chart must be retained in the service user's home while in use.
Any MAR charts which are no longer in use (e.g. from previous months) must be removed promptly from the premises.
Used MAR charts must be retained by the provider for a minimum of 3 years. (Care Home Regulations 2001)

9 ERRORS IN ADMINISTRATION

If a member of care staff is aware of having made a mistake in assisting with medicines, or notices that an error has been made they should immediately notify their manager/senior in charge

If they are unable to contact the manager/senior in charge, the care worker should not delay seeking medical advice from 111 and record outcome.

The manager/senior in charge should ensure the following action is taken:

- Seek advice from the GP or appropriate health professional immediately
- Enter the details of the error in the care record, and on the MAR chart, both of which are
- Kept in the service user's home.
- Make a note of any changes or deterioration in the service user's health or behaviour. Ensure the error is fed into the care provider's incident reporting system, (Datix for Trust staff) and is investigated in order to share learning and prevent recurrence.

10 ADVERSE DRUG REACTIONS/SIDE –EFFECTS

Any medicine can produce unwanted or unexpected adverse reactions and it is not possible to predict who will react and in what way to a specific medicine .If a care worker is concerned about new symptoms a service user is experiencing, the care worker should note any new medicine or recent change in dose over the last few days and inform the manager/senior in charge who should discuss this promptly with the GP, Pharmacist or nurse

11 WASTED DOSES

Any medicine dose that has been prepared (i.e. removed from container) but not administered (dropped, service user refused to take) should be removed from use and disposed of according to the care provider's safe system of disposal

12 DISPOSAL OF MEDICINES

Medicines belong to the person for whom they were prescribed and cannot be removed without that person's permission.
Service users are responsible for disposing of their own medicines safely.
The service user or informal carer should be encouraged to return unused or unwanted medicines to a pharmacy for disposal as soon as they are no longer required or have expired.
Care staff should only remove medicines for disposal if this is specified in the care plan, and only if the care provider fulfils the criteria set out by the Environment Agency. Trust staff may only undertake this task if the service user is unable and there are no relatives or other informal carers to do so. In such circumstances the medicines must be taken directly to the pharmacy or dispensary.
If care staff members remove medicines for disposal, the names and quantities should be recorded and a copy retained with the care record. A receipt should be requested from the pharmacy accepting the items. (See Resource Documents:
http://www.cambscommunityservices.nhs.uk/about-us/policies-and-procedures
Trust staff needing to dispose of doses prepared but not used (no longer in packaging) should follow Trust waste guidance.

13 RISK MANAGEMENT/LIABILITY/MONITORING AND AUDIT

Risks will be managed, monitored and mitigated by the following mechanisms:

- Contract monitoring by the NCC and Nene and Corby CCG contracts department.
- Close liaison between the Care Home Advice Pharmacy team and others in relation to the role of community pharmacists in supporting service users and carers in their own homes.
- Regular monitoring of incidents reported by NCC and CCG Quality teams
- Feedback of learning from incident reports to relevant Trust staff and to independent providers of such care.

14 EQUALITY & DIVERSITY STATEMENT

Northamptonshire County Council, Nene and Corby Clinical Commissioning Groups and Northamptonshire Healthcare Foundation Trust will ensure that this document is applied in a fair and reasonable manner that does not discriminate on such grounds as race, gender, disability, sexual orientation, age, religion or belief.

15 REFERENCES

Care Quality Commission (CQC) Fundamental Standards November 2014, available at

http://www.cqc.org.uk/content/publishing-new-fundamental-standards
The Royal Pharmaceutical Society of Great Britain 2007: The Handling of Medicines in Social Care

16 GLOSSARY

Assessment/ Care assessment	The process of identifying and recording the health and social care needs and risks of an individual, and evaluating their impact on daily living and quality of life, so that appropriate action can be planned
Care Manager/senior in charge	The person responsible for an individual package of care, including assessment, commissioning and review
Care Plan	The Provider's plan which sets out the agreed care objectives, following assessment, and sets out how these are to be achieved.
Care Provider/ Provider	The agency which is commissioned to provide the package of care.
Care Record	The daily record of care actually provided.
Care Staff	Staff employed either by the care provider or service user for the purpose of Providing the care. (Also known as "formal carers")
Care Worker	A member of the care staff
Care Visit	A visit to a service user's home for the purpose of providing care.
Compliance Aid	A device used to aid compliance. This includes special bottle tops or opening devices, reminder charts, Haleraid® devices, eye drop guides, Pivotell ® dispensers. They also include devices such as "multicompartment compliance aids", also known as "dosette boxes", which are usually filled by service users or their families/ friends. They also include pharmacy-filled monitored dosage systems, which are sometimes known as blister-packs (not to be confused with manufacturers' original blister strips)
Healthcare Professional	Healthcare staff that are registered with a professional body e.g. doctor, dentist, pharmacist, nurse, pharmacy technician
Informal Carer	A person who provides care for a service user without receiving remuneration, usually a family member or neighbour.
Medication, Medicine	The terms "medicine" and "medication" are used interchangeably. For the purposes of this policy they relate to medicines prescribed for the service user by a doctor, dentist or non-medical prescriber.
MAR Chart	Medicines Administration Record Chart. The form used to record the administration of medicines.
Monitored Dosage System (MDS)	A system or device which separates different doses and is used as an aid to compliance. It doubles as a container and is prepared by a pharmacist /doctors' dispenser. As such labelling requirements must be complied with, and any particular storage requirements must be taken into account. This includes, but is not limited to, pharmacy-filled blister packs, but does NOT include manufacturers' original blister strips.
Non-medical prescriber	Member of a health profession other than the medical profession qualified to prescribe medicines. This may include some nurses, pharmacists, physiotherapists and certain other professions.
Service User	Person receiving the service of a care provider.

Medicines Risk Assessment	Systematic check of the hazards and risks for the service user and care staff associated with the medicines in use. It addresses problems such as difficulties with compliance, forgetfulness, complex drug regimes, hoarding of medicines etc.

Appendix 1
LEVELS OF ASSISTANCE WITH MEDICINES

(Based on Professional Advice: The administration of medicines in domiciliary care published by the Care Quality Commission (CQC): Quality, Performance and Methods Directorate: January 2009).

Level 1: General Support, also called Prompting or Assisting with Medicine

General support needs should be identified at the care assessment stage and specified in the care plan. Ongoing records will also be required in the care record when care needs are reviewed

General support is given when the service user takes responsibility for her/his own medication. In these circumstances the care worker will always be working under the direction of the person receiving the care.

The support given may include some or all of the following:

- requesting repeat prescriptions from the GP
- collecting medicines from the community pharmacy/dispensing GP surgery
- disposing of unwanted medicines safely by return to the supplying pharmacy/dispensing GP practice (when requested by the service user)
- reminding or prompting by the care worker to a service user to take their medicines. (A persistent need for reminders may indicate that a service user does not have the ability to take responsibility for their own medicines and should prompt review of the care plan)
- manipulation of a container of prescribed medicine under the direction of the service user , for example opening a bottle of liquid medication or removing of medication from a pharmacist monitored dosage system (MDS)
- Use of assisted technology where available

Service users can retain independence by using compliance aids (see Glossary), including monitored dosage systems. These should be considered if packs and bottles are difficult to open or if the service user has difficulty remembering whether he or she has taken medicines.

The monitored dosage system (MDS) will normally be filled and labelled by the community pharmacist or dispensing GP. The service user may qualify for a free service from a community pharmacist if they meet criteria under the Equality Act 2010.

It is best practice that if a pharmacist or dispensing GP does not fill the MDS, the provider should clarify that the arrangements are suitable and minimise the potential for error.

Level 2: Administering Medication

The need for medication to be administered by care staff should be identified at the care assessment stage, specified in the care grid, and recorded in the care plan. Ongoing records will also be required in the care record.

The care assessment or the Medicines Risk Assessment may identify that the service user is unable to take responsibility for their medicines. This may be due to impaired cognitive awareness but can also result from a physical disability.

The service user must agree to have the care worker administer medication and consent should be documented in the care plan. If a service user is unable to communicate informed consent, the provisions of the Mental Capacity Act must be followed.

Administration of medication (Level 2 support) may include some or all of the following:

- When the care worker selects and prepares prescribed medicines for immediate administration
- When the care worker selects and measures a dose of prescribed liquid medication.

- When the care worker applies a medicated cream/ointment/patch; inserts drops to ear, nose or eye; and administers inhaled medication.

The provider should have a system in place to ensure that only competent and confident staff members are assigned to people who require help with their medicines. The provider's procedures should enable care workers to refuse to administer medication if they have not received suitable training and do not feel competent to do so.

Care staff **must** be able to identify each individual medication against the MAR chart therefore this means that domiciliary care workers should only administer medication from the original manufacturer filled containers or a pharmacy or dispensing GP- filled, tamper free Monitored Dosage System (MDS) where each medicine can be individually identified .It must be appreciated that the use of an MDS in this case may attract a fee from the pharmacy or GP surgery

People discharged from hospital may have medication that differs from those retained in the home prior to admission. The provider should provide additional support to care workers when this occurs.

Level 3: Administering Medication by Specialised Techniques

Following an assessment by a healthcare professional, a domiciliary care worker may be asked to administer medication by a specialist technique including:

- Rectal administration, e.g. suppositories, diazepam (for epileptic seizure)
- Insulin by injection
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG)
- Buccal midazolam for epileptic seizure
- Assistance with oxygen
- Warfarin

The care worker must have received training and have been assessed as competent by a recognised training provider or healthcare professional.

The provider must ensure that all staff that are required to administer medication by these techniques are competent and confident to do so.

Appendix 2

Instructions for use of the Medicines Administration Record (MAR) Chart by Care Workers

Care workers who provide level 2 support with medicines to service-users should:

- Only carry out this service if you have received training and been assessed as competent by your manager/senior in charge.

- Only use a MAR chart that has had the medication details added by a person deemed competent by your employers medication policy (this may be a pharmacist, registered manager/senior in charge or other responsible person of a social care service, a doctor or nurse).
- Only alter instructions on a MAR chart if you have been advised by a healthcare professional or your manager/senior in charge..
- Check that:
    - the instructions give all the information and do not say "As directed"
    - dosage timings are clearly indicated on the chart,
    - clear instructions are included for "when required" doses (e.g. maximum number of doses per day and minimum time between doses, and under what circumstances the medication should be given.)

- At the end of each month, start a new MAR chart.

- Contact the responsible person who has provided or completed the MAR chart with any queries regarding the instructions.

- Contact your manager/senior in charge if you have any concerns or problems.

- Check the date on the front of the chart to make sure that it's in current use, and that it is the only MAR chart in use.

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Administer the medicines shown on the MAR chart**,** using the steps below for **EACH MEDICINE, ONE BY ONE**:

1. Check the record and make sure the medication has not already been given

2. Wash your hands

3. Select the medication required and confirm that it is still current by checking the date on the dispensing label.

4. Check that the name of the service-user, the name of the medicine and the instructions on the bottle/box are the same as those on the MAR chart - **IF NOT DO NOT GIVE IT.**

5. Check whether the medicine is to be given by mouth or by another route (e.g. to be inhaled, applied to the skin etc)

6. If oral, ensure the service user is standing or sitting as upright as possible, and has a glass of water available.

7. Give the medicine to the service-user with a drink of water.

8. If applying a cream or medicated patch, or administering a hazardous medicine (see risk assessment) for a service user, ensure you are wearing appropriate disposable gloves.

9. Enter your initials **clearly** on the correct date and time to show you have seen the service-user take the medicine.

10. If the dose is variable (e.g. one or two tablets to be taken) record the **actual amount given** and initial.

11. If the medication is **NOT GIVEN** enter the appropriate code as shown on the MAR chart in the correct box and enter the reason in the service-user's care record. Report this to your manager/senior in charge immediately.

ALWAYS contact your manager/senior in charge should a new medicine appear that is not accounted for anywhere on the chart.
Always bring any concerns to the notice of your manager/senior in charge.
If you make, or detect a mistake, or have any urgent concerns, immediately notify your manager/senior in charge. If your manager/senior in charge is unavailable call the doctor for advice.

IN AN EMERGENCY CONTACT THE SERVICE-USER'S DOCTOR

or APPROPRIATE EMERGENCY SERVICE (111 or 999)

Appendix 3

Frequently Asked Questions - Medicines Management in Domiciliary Care

(Thanks to Cambridgeshire pharmacists for use of these comprehensive FAQ)

Index

Question	**Answer**
1. Service User Factors	
a) Service user unwell, distressed or not their usual self	The care worker must contact their manager/senior in charge for advice, with the agreement of the service user (provided they are able to give permission). The manager/senior in charge should assess the situation and decide on next steps e.g. contact the GP. Guidance must be sought as to whether due medication should be e offered to the service user.
b) Concerns about the service user	**Any doubt or concern** about service users taking or refusing to take their medication, any changes of condition or any possible side effects must be reported to the manager/senior in charge

c) Refusal to take medication	It is an individual's choice not to take medication which must be respected. **Medicines must not be disguised or hidden in food in order to force a service user to take them against their wishes.** They must not be coerced or forced in any way but some degree of encouragement can be given. All refusals must be recorded on the MAR chart and in the care record. Regular or persistent refusals within any one week period must be reported to the manager/senior in charge who must communicate the problem to the GP and request advice regarding the action to be taken if the service user continues to refuse the medicine. The manager/senior in charge should record this communication.
d) Possible side effects	People react differently to different medicines, so it is not possible or helpful to list anticipated side effects. However, should concern arise, the care staff should note whether any new medicine or change of dose to existing medicine has occurred during the last few days. Inform the manager/senior in charge who should discuss this with the GP, Pharmacist or Nurse promptly.

2. MAR Charts	
a) Missing, incomplete or ambiguous, directions on the label	Care staff are **NOT PERMITTED** to assist with these Medications. They should inform their manager/senior in charge who should refer to the supplying pharmacist/ doctors' dispenser.
b) Should inhalers be recorded on a MAR chart?	Yes. They are prescribed medicines.
c) Can medication only be administered from a MAR chart?	Medication should always be administered from the **label** on the packet (which is the pharmacist's instruction, based on the prescriber's instructions). The MAR is a **record** of administration, not an instruction to administer. So it's not essential in order to comply with the law, but it is important to have an accurate, record of events, made **at the time they happened** in case of mistakes or mishaps. If the MAR is not yet available the name of the medicine and the dose given should be recorded in the care record. A note should be written at the top of the current MAR chart reminding the next carer to check in the care record for an item which is not yet on the MAR chart. The manager/senior in charge should ensure the MAR chart is updated at the earliest opportunity. It is essential to check the label against the MAR before administering, in case instructions have changed since the MAR was written.

d) Can all care staff update the instructions on a MAR chart?	Yes if they have had relevant training and are competent any care worker is permitted to update MAR charts.
e) Who should any discrepancies between the label and the MAR chart be reported to?	Staff should report to their line manager/senior in charge who should urgently contact a health care professional to resolve any
f) Where should a discrepancy between the label and the MAR chart be recorded?	Staff should notify their manager/senior in charge. It should be recorded in the care notes together with a note of the action taken and who this was reported to, and the entry signed and dated.
g) What should I do if I make a mistake?	First, ensure the safety of the service user. Staff should report any mistakes to their line manager/senior in charge, but **should not let this delay them in reporting the error to the service user's GP** in case they need to take any action. The staff member should enter the details of the error on the MAR chart and in the service user's care record. The care record entry should include full details of name of the person making the entry date, time and nature of the error action taken at the time name(s) of people contacted any advice received, and from whom any change in the health or behaviour the service user. In addition to this, the provider's incident reporting procedure must be followed. (See Policy, Section 9)
h) Whose responsibility is it to renew the MAR charts at the end of each month	Responsibility for providing MAR charts rests with the care provider. Neither the pharmacist or/ nor the dispensing GP is responsible but may be prepared to provide them on Request.
i) When confirming medication has been taken should staff record their initials in the appropriate box or a tick✓ ?	Carers should always use their initials to indicate that medication has been given. This is so that the manager/senior in charge knows who to ask if there is a query.
j) How should the carer indicate that medication was not given?	Care staff should use the codes provided on the MAR to indicate that medication was not given An explanation should be written in the care record.

k) How should the carer indicate that medication was left out for the service user to take themselves later on? i.e. 'Prepared' for the service	**See question 3e**
l) If staff only visit once a day to administer medication and family assist with morning and lunch medication, where should family record medicines taken.	With the service user's permission: If family are willing to complete the MAR, which is very helpful, their signatures need to be readily identifiable as family members on the chart. They should put their sample signatures on the relevant section on the chart accompanied by a brief description of who they are (e.g. daughter) If the family are unwilling or unable to complete the MAR the care worker could use a defined code to indicate that this medication has been given by a family member

3. Administration of Medicines	
a) Should gloves be worn when applying skin treatments?	Yes, and hands should be washed both before and after applying the skin treatment.
b) Should gloves be worn when assisting with tablets?	**All tablets, capsules etc** should be given using a "no touch" technique so it should not be necessary to Wear gloves. However, it is advisable to do so when administering cytotoxic or hormonal preparations
c) If a service user was sick after taking medication what is considered a safe time to offer another dose? Or is this not advisable?	The safest thing to do here is to record the fact that the dose was vomited and treat it as a missed dose (see 3d below). Do **not** re-administer, as there is a real risk of overdosing. Wait until the next dose is due and carry on from then. Obviously if the service user keeps vomiting doses, the GP should be informed.
d) Missed Doses	If a dose of medicine is missed or omitted this **MUST** be recorded on the MAR chart and reported to the manager/senior in charge, who should investigate. If it becomes known that a dose was missed or omitted during the previous visit a double dose **MUST NOT** be given. The person identifying the error must record this and report it to the manager/senior in charge.

e) Is the carer allowed to prepare medication for a later time?	**No medicine should be 'prepared' for a service user to take later unless this is specified in the care plan, following a risk assessment and only for level 1 assisting with medication** If the carer is preparing medication for the **service user themselves** to take at a later time during the day (e.g. carer only visits am and meds are morning and teatime) then **they can be prepared** and left for the service user to take, provided this is in the care plan, following a risk assessment. o Medicines must not be left out for longer than 24 hours. o If the service user frequently omits to take the prepared medicines the risk assessment must be reviewed Medicines should **never** be left out for administration by anyone other than the service user him/herself. The care plan should describe exactly how the dose is to be prepared, (e.g. left in an egg-cup by the bed).
f) Is it all right to cut or crush a tablet, or to open a capsule, to make it easier for a service user to take it?	Not usually. If the tablet is scored, then it is all right to break it along the score-line. Make sure you wear plastic gloves to ensure that a) the tablets remain clean, and b) that you are protected. Tablet-cutters are available for purchase if this makes it easier. If there is no score-line in the tablet, this **must not** be done without first checking with the pharmacist that it will not affect the medicine or the way it works. Approach the local community pharmacist to see if they will halve the tablets as they dispense them for the service user. It must **never** be done to disguise a medicine (this could constitute abuse). It must not be done unless this is stated in the care plan.
g) Is it alright to cut a tablets without a score-line if the label says to give half a tablet?	No. This must be discussed with the GP and the community pharmacist
h) Is it possible to have a service user on level 1 and level 2 at the same time with their medication?	Yes, it is possible. For example if a service user is managing their own medicines every day well, but they are given eye drops that they cannot manage, you would keep them on level 1 with their regular tablets and only have their eye drops at level 2 with a MAR chart.

4. Syringes and Oral Syringes	
a) If a service user has difficulty taking liquid medicines from a 5ml spoon, is it ok to use a syringe instead?	No problem at all, as long as it is a proper oral syringe (i.e. you must NOT use any kind of syringe intended for giving injections). They should be able to get these from the dispensing pharmacy. If the difficulty is with manipulating the medicine spoons, this is exactly what these oral syringes are intended to be used for.
b) Disposal of injection syringes	Care staff should not handle used injection equipment under any circumstances. The service user should be encouraged to discard used syringes into appropriate sealed sharps containers which may be prescribed by GP's

5. Inhaled Medicines	
a) Inhaler / Spacer: What is the correct technique to use a spacer device?	It is important that the spacer device fits the inhaler The service user should: Shake the inhaler Put one puff of inhaler into the spacer and breathe in deeply through the mouthpiece. Hold their breath for ten seconds (or for as long as is comfortable) then breathe out slowly. It is best to take at least two deeply held breaths for each puff of the inhaler. If it is difficult to take deep breaths, breathing in and out of the mouthpiece several times is just as good. Repeat the step above for each dose/puff needed Wash the spacer once a month - leave it to drip-dry as this helps to prevent the medicines sticking to the sides Spacers should be replaced at least every year, especially if used daily Reference: www.asthma.org.uk/
b) How should staff dispose of an inhaler?	The advice given on a service user information leaflet states: *'Medication should not be disposed of via waste-water or household waste.'* Ideally an inhaler should be returned to a pharmacy for disposal by the service user or their family/carers. The canister is pressurised and may contain residual medication. Asthma UK are promoting a recycling venture to reduce landfill and greenhouse gases Participating pharmacies can be found by visiting **www.gsk.com/uk/consumers/complete-the-cycle.html**

6. Liquid Meds	
How long can liquid medicines be kept after opening?	**As long as medicines have been kept according to the manufacturer's instructions, most of them can be kept** until the expiry date on the bottle. However, some have a reduced shelf life after opening and this information will be found on the Manufacturer's label or the pharmacy label. The Patient Information Leaflet (PIL) in the packet will also contain any relevant information. If in doubt, always refer to the manufacturer's recommendations.

7. Eye drops	
a) Should infection in the eyes be being treated with two different bottles or is one sufficient?	The decision rests with the prescriber as to whether one bottle or two are prescribed.
b) No date of opening on eye drops	Look at the pharmacy label on the drops. If supplied less than 28 days ago the drops are safe to use. If the date is more than 28 days ago do not use. (NB some moisturising eye drops e.g. Systane and Hylo-forte are provided in devices that can be used for more than 28 days. Check the manufacturer box

8. Patches	
a) How should used patches be disposed of?	It is important that patches are disposed of safely, as they still contain medicine residue. The patches should be folded sticky sides together and then ideally returned to the local pharmacy for disposal, as household waste medicines. It may be sensible to keep them in an empty packet until able to return them, but it is important that this is clearly labelled as "used patches" and stored safely, away from un-used patches until it is possible to return them. If it is not possible to return them to the pharmacy, it is acceptable to dispose of them in the **yellow-lidded** sharps bin, if there is one available, or small quantities can be placed in the household waste.

9. Methods to help service users maintain independence with their medicines. Service users may have good understanding of their medicines and wish to manage them themselves, but they might have difficulty, for example, reading standard print on labels, removing tablets from manufacturer's blister strips, remembering when to take medication, administering eye drops, etc.	
What systems or aids are available to assist people to take their medicines themselves and retain independence?	These include: • Large print label • Device for removing tablets/capsules from blister strips (e.g. Medi-popper®, Pill Popper • Patient medication reminder charts listing medicines, indications, when to take and what dose • Tick charts for service user to record when dose taken • Talking labels that can be recorded with service user's name, medicine and direction • Medication reminder alarms (available as a stand-alone device, incorporating a multi-compartment aid, or as a smartphone app) • Devices to help administer eye drops (e.g Opticare®, Autodrop®, Autosqueeze®) or to actuate inhalers (e.g. Haleraid®) Multi-compartment compliance aids which can be re-useable (re-filled by the service user or their relative e.g. Medidos©) or sealed (filled by the pharmacy)

10. Service user's own medication system.	
What should the care provider do if the service user organises their medicines in unconventional containers (e.g. sets them out in egg boxes or saucers)?	Check with their pharmacy that the tablets can be out of the packaging for the time concerned. If the service user is able to describe correctly how they take their medicines and it correlates with the list from their GP, they should be allowed to continue

11. Monitored Dosage Systems (MDS, Dossette Boxes, Multi-compartment compliance aids, MCA)	
Why are you using a Monitored Dosage System? Monitored Dosage Systems should only be used when they enable the service user to remain independent, i.e. the service user does not need a carer to administer medication at level 2. Staff members who fulfil the training and competency requirements should administer from pharmacy original packs or a pharmacy filled MDS which enable them to identify each individual tablet they are giving.	
a) If a tablet is dropped can I use tomorrow's section?	Staff should not try to pick out individual tablets. This is not only risky in terms of correct identification but will also leave the next day's supply with one missing tablet. If the service user's medication is the same every day it is sensible to use the complete supply from the next day and disregard everything in today's section. If a service user takes **any** of their tablets once a week, the above advice is not appropriate and the immediate solution would be to use the same day and time section from the blister pack for the next week and continue to use that blister pack from then on. In all of the above situations a further prescription would be required in order to obtain replacement supplies.
b) Are carers able to assist with family filled dossette boxes?	Carers are able at level 1 to **prompt only** service users to take medication from a family- filled dossette box.
c) Is it all right to put all of a services user's tablets into one pot and administer them altogether?	No. The carer must be able to take responsibility and sign for each individual medicine administered. If the service user did not take one of the tablets for any reason, the carer would not be able to tell which one it was. Therefore each medicine must individually be identified, checked against the label and MAR chart, removed from its packaging, administered and signed for, one by one.

d) Is it ever acceptable for care workers to administer medicines from a monitored dosage system (MDS)?	i) Some MDS systems (usually only available to care homes) may have one medicine per "blister" and each blister has a direction label. These may be treated as if they were original packs and carers are therefore able to administer from these. ii) With regard to the more common type of MDS, such as multi-compartment compliance aids*, support provided by care staff should be limited to 'prompt only' (Level 1 support). In very exceptional cases it may be considered appropriate for care staff to administer from a MDS. This must **ONLY** be done following a medicines risk assessment and documented in the care plan In this case a MAR chart must also be used. *Multi-compartment compliance aid: A device with pockets for different days of the week and times of the day. Each pocket may contain a number of different tablets.

12. Warfarin	
a) Warfarin	Particular care must be taken to check the currently prescribed dose, which should be recorded in the service user's yellow book or other anticoagulant record. The service user should have blood tests (INR) at variable intervals, which do not normally exceed 8 weeks. Blood tests should also be recorded in the yellow book or other anticoagulant record. Care staff should be vigilant and aware of arrangements for individual service users. **NB: new advice:** If the yellow book or other anticoagulant record is not available or not up to date care staff should refer to their manager/senior in charge who should urgently seek clarification. If unable to obtain clear instructions from a healthcare professional, the manager/senior in charge should instruct the member of staff to continue according to existing dosage instructions until clear information can be obtained.
b) How do I know what dose of warfarin a service user should take?	Current dosage instructions for warfarin should be found in the yellow book or on a sheet sent from hospital anti-coagulation clinics sent to the service user. The dose will always be expressed in milligrams (mg) and **not** as number of tablets. It may need to be made up with a combination of strengths – e.g. a 4mg dose may be given as (four x 1mg tablets), **or** (one x 3mg and one x 1mg tablet). If in doubt, check!!!!

c) Should warfarin be recorded on the MAR chart?	Yes. Warfarin is a prescribed medication and should be recorded on the MAR chart. In addition to care worker's initials, the dose given should be recorded on the MAR chart in milligrams
d) Is warfarin a controlled drug?	No

13. Controlled Drugs	
a) What is a controlled drug?	Controlled drugs are controlled under the "Misuse of Drugs Act 1971" to prevent their misuse. These drugs have potential to cause addiction and harm. Therefore they are more likely to be stolen.
b) Do controlled drugs have to be stored differently to other medication within a person's home?	No. However, security of all medicines should be considered at the risk assessment.
c) Can care staff assist with controlled drugs on an "as required" basis?	The same rules apply as for all other "as required" medicines. i.e. provided the doctor specifies the dose, minimum time interval between doses, maximum number of doses per day and reason for use. Therefore they must also know the time of the previous dose. If service users require doses on a more than occasional basis, the care worker should inform their manager/senior in charge who should draw this to the attention of the doctor.

14. Oxygen	
a) Oxygen cylinders	Suspected problems with oxygen cylinders e.g. leaks, should be referred by care staff to their manager/senior in charge who should refer to the oxygen supplier. Risk Assessments should be completed and stored in the service user's home with the care plan
b) Should service users on oxygen have a sticker/notice on their front door to show they have oxygen within the home?	No. A sign could attract unwanted attention and expose the service user to crime and abuse.
c) Do we need to report a service user using oxygen to the fire service?	No. The oxygen provider is required to immediately inform the fire service.
d) Is oxygen level 3,	Assistance with oxygen is level 3.

15. Level 3 tasks	
All training and competence, whether or not under delegation, should be evidenced by training and supervision records.	
a) Can level 3 tasks be delegated?	Level 3 tasks are those requiring the use of specialised techniques, such as the administration of medicines via PEG tubes, or the administration of insulin by injection.
b) How can independent care staff access training for level 3 tasks?	Any care-worker required to perform a level 3 task for a service user must be given the relevant specialist training. The provider must source this themselves.
c) Is administration of a diabetic rescue medicine (e.g. glucose gel) a level 3 task?	No. But, as with everything, staff should be trained and competent. There are issues about giving Glucogel to service users who are unable to swallow or lapsing in and out of consciousness (risk of choking), and they would need to establish whether the service user is a) conscious and b) able to swallow. Also, its use should be reported to a healthcare professional every time. **The best advice in this situation is to call 999 and take their advice.**
d) Is blood sugar testing a level 3 task?	No. But staff would need to be trained and competent.
e) Is the application of a rectal cream or suppository, or a vaginal pessary a level 3 task?	Yes

f) Are nebulisers a level 3 task?	No, but staff should be trained and competent.

16. Medication Risk Assessments	
a) Is there a specific form for medication risk assessments?	No. Independent providers should have a suitable risk assessment form that reflects this medication policy and it's requirements
b) How do we know if the service user has cytotoxic or other medication that should not be handled?	A community pharmacist should be contacted for advice
c) Do we need to do medication risk assessments for all levels of support (1, 2, and 3)?	Yes. Even at level 1 support only, the risk assessment may highlight issues which pose a risk to the service user, staff or others and trigger a review. For level 2 or 3 support it is an essential tool for communicating risks and actions to reduce them to staff. A copy of the completed risk assessment should be available in the service user's home, and staff should be encouraged to refer to it regularly and be aware of its content.

d) Do we need to do a medication risk assessment when there are prescribed medicines in the service user's home even if we have no involvement with them at all?	There is no requirement for this, but providers can decide to do one if they wish. The manager/senior in charge's assessment should indicate whether support is required with medicines, and at which level. However, care providers should remain vigilant for changes in the service user's needs.

17. Day Centres	
a) If a service user goes to a Day Centre and Day Centre staff will be administering medication should the MAR chart be sent with them?	No. The MAR chart belongs to the agency providing the care, and is an important means for the agency to determine whether a medicine has or has not been administered by a member of their staff. It should clearly record when the medicines are not given because the service user is at the Day Centre. It is the Day Centre's responsibility to keep their own records. There is a need, however, for good communication between the agency and the Day Centre staff, to ensure that the medicines are given correctly, and a **copy of the MAR chart** (for information) may facilitate this.
b) If a service user goes to a Day Centre should the MAR chart go with them if they are to self-administer their own medicines at the day centre?	No. Provided the service user will be self-administering the medicines, they can take them with them to the day centre and it is not necessary for there to be a record on the MAR chart. Any assistance with preparation for this should be recorded in the care record, and the care-worker should clearly record each time this happens.

c) If a service user goes to a Day Centre, does the medication need to be sent in the original packaging?	If the Day centre staff will be administering the medicine they will require a labelled supply, so, yes, the original packaging should be sent.

18. General	
a) Why are there different instructions about taking Calcium supplements when taking Alendronic Acid tablets?	If Calcium is given at the same time as the Alendronic acid (also called alendronate, or sodium alendronate) it can stop it getting into the bloodstream, so doses should be spaced well apart. Different prescribers give different instructions as to how to achieve this and the following options are all equally valid: Avoiding calcium on the same day as alendronic acid Taking the calcium in the afternoon if alendronic acid is taken that morning. Taking the calcium in the afternoon routinely.
b) What is the difference between PR/SR/MR – Prolonged Release/ Slow Release / Modified Release?	These terms are all used interchangeably in most cases. Some manufacturers have their own branded terms for these. In most other cases MR means slow release. None of these formulations should be broken unless either there is a score-line in the tablet, or it has been confirmed by a pharmacist, and they should never be chewed or crushed.
c) If a GP has prescribed paracetamol as PRN and the service user runs out, can they purchase their own to keep in the medication cupboard and care staff sign the MAR chart as usual?	Purchased paracetamol becomes a household remedy, and would need to be treated in that way. There is a possibility of interaction with other prescribed medicines which will be reviewed by the prescriber on each occasion it is prescribed. This may seem unreasonable if it is known that the service user is allowed it on repeat, but there are too many variables to be able to say that this is safe practice. It should be deemed as urgent to obtain a new supply from the service users' GP or OOH

d) Can carers assist with non- medicinal procedures? e.g. TENS,CPAP device , Suction, dressings	TENS machines, CPAP machines and suctioning are not classed as medication and can be loaned from health care professionals or purchased (TENS). If carers are being asked to assist the agency/trust must assure themselves that appropriate training has been provided and that a manager/senior in charge is aware of what to do and how to do it as well as having confidence that their staff are competent and confident in assisting. It would all need to be documented in the care plan. Dressings are most likely to be a nursing task though may be delegated if appropriate (within trust).
e) Can we thicken medication with a thickener?	A thickener may be prescribed for a service user with swallowing difficulties. If medication needs thickening it should be clearly documented in the care plan and each medication should have instruction on the label to say it can be mixed with a thickener if in liquid form. If tablets or capsules the label should indicate that it can be crushed or opened as well as being mixed with thickener.

19. Creams in Domiciliary Care	
Do all creams have to be prescribed and recorded on the MAR chart when administered?	Creams and ointments generally fall into one of 3 categories. 1. Those which can be purchased in a variety of outlets, and which are used for moisturising the skin or as a barrier to protect the skin. 2. Those which contain potent medicines and have to be prescribed. 3. Those which are available for purchase, but which do contain medicines which could possibly interact with prescribed medicines.

a) Creams purchased by the service user to moisturise or to protect the skin or on the advice of a community / district nurse for this purpose.	As long as the service user has used the preparation before, or it is being used on the advice of a community nurse these may be administered under the heading of ”personal care “ A prescription is not required and it is not necessary to record administration on a MAR chart. It should be recorded in the care plan as part of personal care in the usual way
b) Creams prescribed by the doctor	These must be treated in the same way as all other prescribed medicines. Policy states that the application of a cream is automatically a Level 2 task, so a record should always be made on the MAR chart.
c) Creams which can be purchased over the counter, but which contain medicines	These should be treated in the same way as all other ‘over-the-counter’ medicines. i.e. care staff must not assist in the administration of such creams or ointments. Examples include Ibugel, Anthisan, and hydrocortisone cream.
d) What expiry date should we use with creams/ointments/gels?	Use the current Northamptonshire expiry date guidance available from the Care Home Advice Pharmacy team 01604 651356 Tubs with pumps – manufacturers expiry Creams in a tub where the lid has to be removed to use the cream -manufacturers expiry Creams in tubes - manufacturer’s expiry date UNLESS there is instruction that it should be discarded sooner once opened.

20. Toothpastes and mouthwashes	
Should use of high dose fluoride toothpastes be recorded on a MAR chart?	High dose fluoride toothpaste e.g. sodium fluoride 1% dental paste SF or sodium fluoride 5000ppm SF (Duraphat) are prescription only medicines so will need to be added to the MAR. Carers should be trained and assessed as competent to use these products.
Should use of prescribed mouth washes be recorded on a MAR chart	Yes as they have been prescribed. For products bought by the service user or family these should be incorporated into a daily mouth care plan. Best practice is to follow advice in the “Delivering better oral health “ toolkit

	https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention

Appendix 4 – Levels of Assistance Flow Chart

I am requesting my service user's prescription

I collect the medicines from the pharmacy

I dispose of unwanted medicines (back to the pharmacy)

I remind my client that his/her medicines are due

I remove lids from medicines bottles or remove tablets from a monitored dosage system BECAUSE my client cannot do this AND he/she asks me

I apply a cream that is NOT prescribed but is a general moisturiser or skin protector and is part of the normal daily skin routine detailed in the care plan

LEVEL 1 this is also called "Prompting or assisting with medicines and DOES NOT need a medicines administration record (MAR) sheet

I select and take the tablets out of the medication boxes and give them to the client as they are unable to remember this for themselves

I select and measure out a dose of liquid medication

I apply a PRESCRIBED cream, ointment or patch

I select and administer eye or ear drops or select and help administer an inhaler with or without a spacer device

LEVEL 2 this is also called "Administering medicines ".You must have been trained to give medication and be deemed competent .You must be able to individually identify each medication and record the administration on a MAR

I administer rescue medication for epileptic seizure either rectally or buccally or give insulin or oxygen or give medicine via a Percutaneous endoscopic gastrostomy

I administer warfarin

LEVEL 3 this requires specialised training. All administration will be recorded on a MAR

Appendix 5 - Summary for Domiciliary Care providers

POLICY	Establish, document and maintain an effective system by which medicines are managed safely and securely that reflects the policy and procedure for medicines management in the domiciliary setting (Adults) for Northamptonshire
	Designate an experienced senior member of staff to be responsible for management of this system
TRAINING	Ensure that all care staff members providing assistance with medication have been trained and are competent to provide the appropriate level of assistance required for the service user as assessed by the commissioner of the package of care
RISK ASSESSMENT	Complete and maintain a medicines risk assessment for each service user and inform commissioner if level of assistance with medication changes

Level 1

Staff members should have an awareness of medicines, clearly understand the limits of the support needed and report to their manager or senior if they have concerns .

No MAR required

Level 2

Staff members should have received training in medicines management and been assessed as competent. The competency should be re-assessed at least annually.

They should be able to identify each individual medicine

MAR required

Level 3

Staff members should have received specialised training that covers the specified medication below:

- Rectal administration e.g. suppositories, diazepam (for epileptic seizure)
- Insulin by injection
- Administration via a Percutaneous Endoscopic gastrostomy (PEG)
- Buccal midazolam for epileptic seizure
- Assistance with oxygen
- Warfarin